



Ohio Administrative Code Rule 5160-1-02 General reimbursement principles.

Effective: December 1, 2019

This rule describes general principles regarding reimbursement of services by medicaid. Reimbursement may be subject to additional administrative criteria as described in agency 5160 of the Administrative Code.

(A) A medical service is reimbursable if:

- (1) The service is determined medically necessary as defined in rule 5160-1-01 of the Administrative Code.
- (2) The service is agreed to by the medicaid-covered individual or the medicaid-covered individual's authorized representative.
- (3) The service is rendered to a medicaid-covered individual as defined in division 5160:1 of the Administrative Code.
- (4) The service is provided within the limits of the medicaid-covered individual's medicaid benefit package.
- (5) The service is provided within the scope of practice of the rendering provider as defined by applicable federal, state, and local laws and regulations.
- (6) The service is rendered by a provider assigned to or selected by the medicaid-covered individual or medicaid-covered individual's authorized representative, with the exception of medicaid-covered individuals enrolled in the coordinated services program as defined in Chapter 5160-20 of the Administrative Code.
- (7) The service is rendered by an eligible provider or panel provider for managed care plan participating provider.



(B) Special conditions regarding medicaid reimbursement.

(1) If a service is charged to medicaid at a rate greater than the provider's usual and customary charge to other patients for comparable services, the provider will be reimbursed at the provider's usual and customary charge or medicaid permitted reimbursement rate, whichever is lower.

(2) Inpatient and outpatient hospital services billed by hospitals reimbursed on a prospective payment basis, as defined in Chapter 5160-2 of the Administrative Code, will not be paid, in the aggregate, more than the provider's customary and prevailing charges for comparable services.

(3) Medicaid will not provide reimbursement for a provider-preventable condition as defined in 42 CFR 447.26 (as in effect on October 1, 2018). The prohibition on provider-preventable conditions shall not result in a loss of access to care or services for medicaid-covered individuals.

(C) Additional reimbursement principles are applicable to the following:

(1) Services delivered through the medicaid managed plans as described in Chapter 5160-26 of the Administrative Code.

(2) Habilitation services as defined in 42 USC 1396n(c)(5) (as in effect on October 1, 2018) and permitted in agency 5160 of the Administrative Code.

(D) Commingling is prohibited. For the purposes of this rule commingling occurs when the sharing of office space, staff (employed or contracted), supplies, equipment, or other resources with an on-site practice or provider organization owned or operated by the same provider, physician, or non-physician practitioners results in one or both of the following:

(1) Duplicate medicaid reimbursement for services performed; or

(2) A provider selectively choosing a higher reimbursement rate for the services performed.